EXHIBIT A

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

IN RE: MULTIPLAN HEALTH INSURANCE PROVIDER LITIGATION	Case No. 1:24-cv-06795 MDL No. 3121
This Document Relates To:	Hon. Matthew F. Kennelly
ALL DIRECT ACTION CASES	

DIRECT ACTION PLAINTIFF FORMATTED DISCOVERY FORM

Plaintiff's Name: _____

Please provide the following information for each physician, hospital entity, or provider (collectively referred to as an "Entity"), on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to all questions with respect to the Entity that is asserting claims against Defendants. Any questions using the term "You" refer to the Entity involved in the claim.

If you do not have enough room on this Formatted Discovery Form to fit your complete response to any question or request, please either complete that response on a supplemental page, or on additional copies of the pages for which you need more room.

If you are filling out this form, please use the following definitions:

- **"Balance Bill"** or **"Balance Billing"** means the amount You bill a patient for the difference between the amount You charge for OON Healthcare Goods and Services and the amount received from the patient's health plan.

- **"Claim"** means a bill submitted to a patient or a claim for reimbursement submitted to a payor for goods or services provided by You.

- **"Document"** means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mail, cassettes, videotapes, DVDs, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, phone-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form. Excluded from this definition are documents that are protected by the attorney-client privilege and/or the work-product doctrine.

- The **"relevant time period"** solely for purposes of this Formatted Discovery Form refers to the time period January 1, 2019 to present, unless otherwise specified or agreed, or unless the Court determines that a different relevant time period applies to discovery in

this case, in which case the relevant time period would be the Court-determined time period.

- "**OON Healthcare Goods or Services**" means a product or service provided by healthcare providers to a patient where the provider is not in-network with the patient's health plan. It includes what is referenced in the Consolidated Class Action Complaint and Master DAP Complaints as "out-of-network goods and services."

- "**Structured Data**" means data that are stored in a structured format, such as relational database management systems (e.g., SQL, Oracle, DB2, Microsoft SQL), NoSQL or nonrelational databases (e.g., Redis, Amazon DynamoDB, Casandra, Scylla, HBase).

- "**Payor" or "Payer**" means any Person, company, or other entity that provide compensation to providers for medical services, including but not limited to, commercial insurers, health plans, the operators of any health plans, health plan claims administrators, third-party administrators, the Center for Medicaid and Medicare Services ("CMS"), Medicare Advantage/Managed Medicare or Managed Medicaid plans or organizations, AHCA, and self-pay/uninsured patients.

- **"You" or "Your"** refers to the Entity with allegations against Defendants.

- The use of a singular form of any word includes the plural and vice versa.

To the extent any of your responses to this section have changed during the relevant time period, please provide responses that reflect those changes. For example, if the Entity has changed names during the relevant time period, please provide all names and the relevant years the Entity operated such name(s).

In completing this Formatted Discovery Form you are under oath and must provide information that is true and correct to the best of your knowledge after reasonable inquiry. This Formatted Discovery Form must also be supplemented if additional information or documents become known after completion.

Information within this Formatted Discovery Form is subject to the Protective Order entered as Case Management Order 12 in the above-captioned matter and will only be used for purposes related to this litigation.

I. DOCUMENT REQUESTS

1. For 2023-2025, Documents that evidence or describe Your policies, procedures, or practices regarding billing or payment of Payers or patients for OON Healthcare Goods and Services, including but not limited to Balance Billing, any discounts, waivers, payment plans, or other practices used to determine how much patients will be billed or pay for services.

2. For 2023-2025, The standard Documents, assignments, paperwork, policies, or disclosures that Your practice provides to patients receiving OON Healthcare Goods and Services, including but not limited to documents relating to insurance coverage, disclosure of pricing, financial responsibility for services, patient financing, and any fees, howsoever styled, charged to patients.

3. For 2023-2025, Your annual financial statements, balance sheets, and income statements.

4. For 2023-2025, Your chargemasters.

II. INTERROGATORIES

1. Identify each Payor whose members You refused to treat on an out-of-network basis because of alleged out-of-network underpayments from that Payor, and the time period(s) of any such refusal.

2. Identify by year the number of patients You pursued legal action against or sent to collection agencies for unpaid amounts for OON Healthcare Goods and Services.

3. Describe the methodology(ies) You used to set and modify Your billed charges during the relevant time period, including any surveys, databases, benchmarking services, or consultants used by You for these purposes.

III. PROVIDER INFORMATION

A. Entity Name: _____

B. Your principal place of business: _____

C. The state(s) in which You have provided healthcare goods or services during the relevant time period: _____

D. The top 5 metropolitan statistical areas or geozips in the United States from which You draw patients by number of patients:_____

E. Entity's owners: _____

F. Your affiliations:_____

G. Nature of Your practice: _____

1. Number of healthcare practitioners employed by You: _____

2. Total employees employed by You: _____

3. Healthcare specialty

☐ Primary Care/Family Practice/Internal Medicine
☐ Specialty Practice
☐ Mental Health/Addiction/Treatment
☐ Diagnostic and Testing Facility
☐ Surgical
☐ Hospital
☐ Anesthesiology/Pathology/Radiology
☐ Urgent Care
☐ Emergency Care
☐ Dental
☐ Chiropractor
☐ Other (specify):

4. Primary service location (clinic, hospital, ASC, etc.): _____

H. Years active: _____

I. National Provider Identifier: _____

J. Tax ID number(s): _____

K. List the top 10 Payors to which You submitted out-of-network claims by (a) dollar volume and (b) number of claims during the relevant time period, in descending order of payors by (a) dollar volume and (b) number of claims: _____

_____

_____

_____

L. List the top 10 Payors to which You submitted in-network claims by (a) dollar volume and (b) number of claims during the relevant time period, in descending order of payors by (a) dollar volume and (b) number of claims: _____

_____

_____

_____

M. List Your top 10 most frequently billed CPT codes, HCPCS codes, and DRG codes (if applicable) from 2023-2025 on an annual basis, in descending order of frequency for each type of code, and Your billed charge for each code: _____

_____

_____

_____

N. List (1) all commercial Payor networks and (2) all lease, wrap, or rental networks with whom You were contracted specifying the timeframes for each Payor or lease/wrap/rental network that You were contracted.

O. List the structured data systems used for Your practice during the relevant time period (whether directly or through any vendors, third party billing administrators, or any other agents), and confirm whether such systems include patient responsibility amounts, amounts billed by You to patients, amounts You collected from patients, and claim number (or other identifier (e.g., Social Security number, patient name and address) for linking such data to Payer claim data. Note: those Plaintiffs providing structured data samples by July 24, 2025, pursuant to previous orders of the Court, may refer to such samples as their answer to this question: _____

P. List any surveys, databases, benchmarking services, or consultants You used or were used on your behalf to set or modify Your billed charges during the relevant time period: _____

IV. CLAIMS INFORMATION

Please provide the information requested in the chart below:

Year	Annual gross revenue	Total number of in-network Claims	Total number of out-of-network Claims	Total number of Claims for OON Healthcare Goods and Services which you sent Balance Bills	Total amount of revenue You collected from patients for OON Healthcare Goods and Services
2019					
2020					
2021					
2022					
2023					
2024					

DECLARATION

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that all of the information provided and in connection with this Formatted Discovery Form is true and correct to the best of my knowledge information and belief at the present time.

Further, I acknowledge that I have an obligation to supplement the above responses if I become aware of additional responsive information, or if I learn that they are in some material respects incomplete or incorrect:

Date:_____, 2025 Signature:_____

Print Name:_____